

Health Education: a Federal Overview

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THE VIEW FROM ANY FEDERAL WINDOW tends to be foreshortened and in curious perspective. It is likely to focus on those events which are "up close," within the Federal establishment itself. In a field like health education—with activities widely diffused within government and still more widely dispersed across the national scene—this foreshortened perspective can leave the false impression that government in general, and the Federal Government in particular, is "where the action is."

The truth, of course, is quite the reverse. Health education of individuals and families happens, or does not happen, where people live, in their homes, workplaces, or communities. That is where people learn and practice, or do not learn and do not practice, means for keeping well, raising the quality of their lives, and how to use the health care services available to them. Government may, and often does, propose. Sometimes its proposals are sweetened by the offer of various forms of support. But local institutions and individual persons dispose. What they do determines whether or not health education fulfills its great potential for improving our national health status.

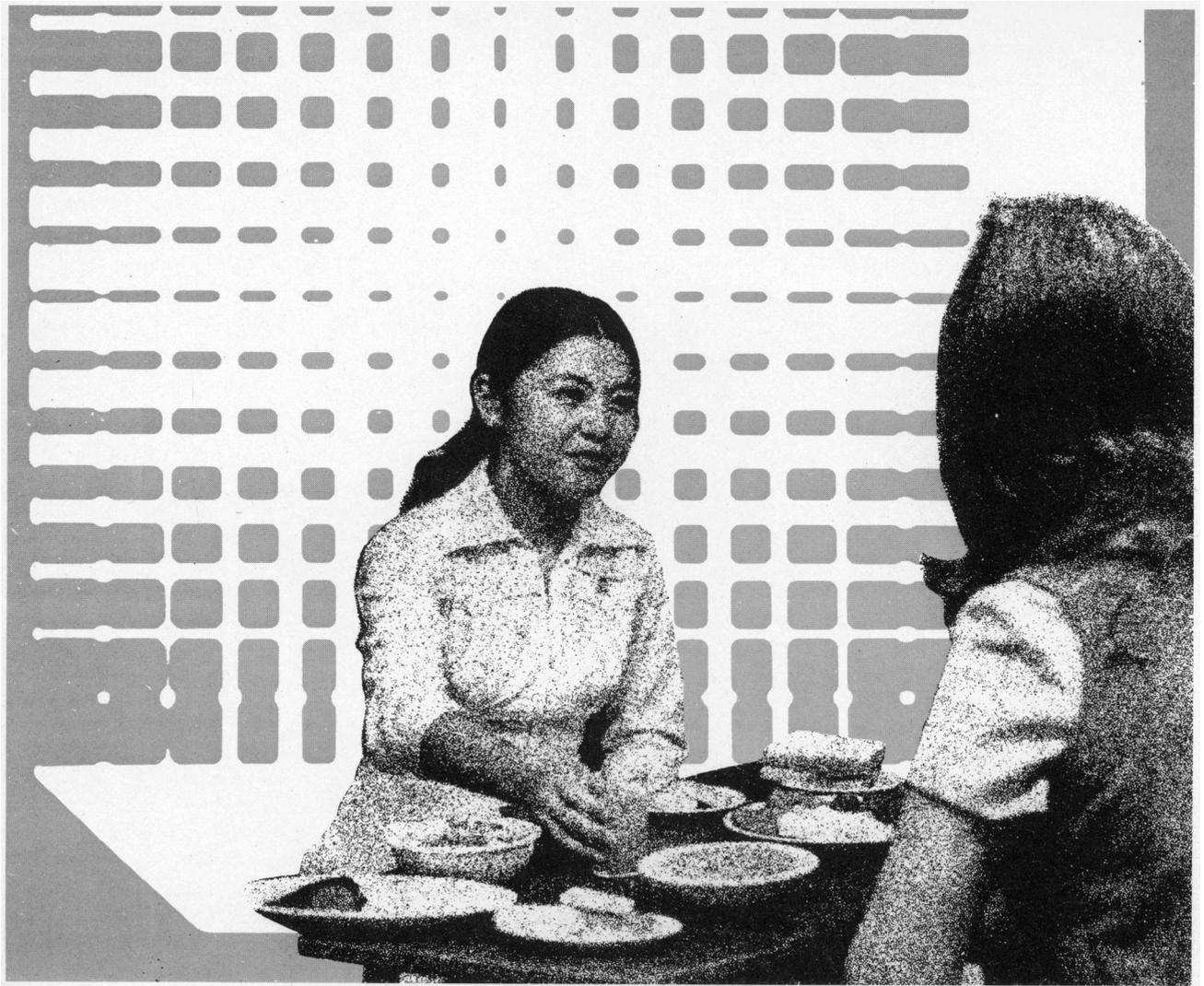
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Therefore this "Federal overview" should not be looked upon as a national overview. It seeks to outline briefly the recent series of events leading to the arrangements which now exist within the Federal Government and to describe those arrangements within the Department of Health, Education, and Welfare (DHEW) and, to a limited extent, elsewhere in the Federal establishment. Examples will be mentioned of activities where the public and private sectors are coming together. But they are merely illustrative, and are neither the only nor necessarily the best programs in action. Programs overlooked in this overview are oversights, and unintentional.

Historical Backdrop

The roots of health education run deep in the history of public health. Any of several dates can be chosen for its emergence as a recognized component of public health activity. Dr. Godfrey Hochbaum has recently characterized its early period in this way (1):

Prior to its first period of transition, 25 years ago, health education was guided principally by the notions that its main goals were the prevention of certain categorical diseases, that the achievement of these goals depended on efforts to get people to carry out certain actions, that their failure to carry these out was due primarily if not totally to ignorance, and that therefore the mission of health education was first and foremost to remove such ignorance. Once done, it was assumed, the desired actions would be taken as a matter of course.



The transition to which Hochbaum alludes, taking place in the years following World War II, was based on the somber realization that there is much more in behavior than was dreamt of in the philosophy of those earlier years. Rational man does not necessarily, and perhaps not even frequently, behave with respect to his health as his intellect might dictate. The challenge to those who would influence health behavior has been summed up succinctly by Dr. Mohan Singh (2):

Hearing is not knowing; knowing is not understanding; understanding is not believing; believing is not doing.

During the decades of the 1950s and 1960s, a period of dynamic change in the health care field and explosive growth in the Federal involvement in health, the fortunes of health education as an identified force waxed and waned. Much excellent work was done, particularly in academic centers, in expanding the base of knowledge and range of disciplines involved in deal-

ing with health behavior. Major "campaigns" were launched, with educational intent, directed toward a series of health problems which seemed susceptible to successful educational intervention—cigarette smoking, alcoholism, drug abuse, family planning, and many more. Some of these were based on the old assumption that communication of information solves the problem. Others were more sophisticated.

But, for a variety of reasons including the increasing national emphasis on delivery of therapeutic care, the health education movement remained dispersed and fragmented, and a progressively smaller share of the growing national health investment was being dedicated to the fields of education and prevention.

Development of a Plan

A significant turning point came in the President's 1971 Health Message to the Congress, which stated that

“... there is no national instrument, no force to stimulate and coordinate a comprehensive health education program” (3). The immediate outgrowth of this statement was the appointment of a President’s Committee on Health Education, which was charged with recommending “ways to develop in the general public a sense of ‘health consumer citizenship’.”

The Committee, made up of distinguished citizens representing a broad variety of disciplines and interests, was chaired first by Joe Wilson of Xerox Corporation and subsequently, following Wilson’s untimely death, by R. Heath Larry of United States Steel Corporation. A series of public hearings in eight major cities across the country generated both significant input and heightened interest in the long-neglected subject. Although the initial charge of the Committee had chiefly stressed leadership in the private sector, as a major expression of voluntarism, the Committee concluded that greatly increased emphasis would be required in governmental as well as private endeavors if a health education program equal to the challenge were to be developed.

The Report of the President’s Committee on Health Education was delivered to the White House in 1973. Among its significant recommendations the principal one called for the establishment of a National Center for Health Education, based in the private sector but with substantial Federal support. The Committee also recommended “That a focal point be established within the Department of Health, Education, and Welfare to work with all Federal agencies to help make the Federal Government’s involvement in health education more effective and more efficient” (4).

Caspar W. Weinberger, then Secretary of DHEW, to whom the report was referred for appropriate governmental action, asked his Assistant Secretary for Health, Dr. Charles C. Edwards, to recommend a course of action. A task force, with representatives of the six Public Health Service agencies and liaison representation from the other components of DHEW concerned with the problem, submitted a proposed plan of action to Edwards in December 1973.

Following review throughout the Department and revisions based upon this staff review, Secretary Weinberger submitted to the President on May 8, 1974, an action plan which, in the words of his transmittal memorandum, “. . . reflects a workable way of commencing implementation of the Committee’s principal recommendations.” As summarized in this memorandum, the action plan called for:

1. Federal support, conditional upon matching funds from the private sector, to initiate an outside-the-government health education consortium, to be known as the National Center for Health Education.
2. Creation of a Bureau of Health Education within the Center for Disease Control to serve as the Department’s operating focus for health education activities.
3. Establishment of an Intradepartmental Health Education Committee, staffed by the Bureau of Health Education,

which will assure effective coordination of Federal resources devoted to health education purposes.

Three years after the initiation of the process, the President in his 1974 Special Health Message to the Congress outlined the plan and observed, “Potentially, these actions could sharply improve the effectiveness of health education through many channels, including our schools, mass media, neighborhood and community organizations and the health care system itself” (5).

Initial Action Steps: The National Center

Before all the bureaucratic i’s had been dotted and t’s crossed, the Center for Disease Control (CDC) signed a contract with the National Health Council (NHC) to explore in depth the feasibility and desirability of the primary recommendation of the President’s Committee concerning the formation of a National Center of Health Education based in the private sector. Specifically, the National Health Council was asked to answer a series of hard, practical questions:

What would such a center do? How should it be constituted and governed? Would it in fact serve an essential purpose, useful to the many agencies and organizations, professional, voluntary, and industrial, already active in health education? Perhaps most important of all, was there a solid source of initial and ongoing financial support for such a center in the private sector? For it was strongly felt that a nominally “private” national center which in fact was dependent for its existence on Federal funds was doomed to failure.

The NHC responded to this complicated challenge. With a small but highly competent project staff and a representative policy committee under the chairmanship of Arthur C. Nielsen, Jr., who had been a member of the President’s Committee, they presented to CDC in August 1975 a final report urging the formation of a center and supporting the recommendation with persuasive data and argumentation. Most convincing of all, as a byproduct of the work on the project, a National Center for Health Education was in fact in the process of formation, strictly as a private sector initiative, by the time the NHC project report was delivered. The center was formally brought into being on October 1, 1975, with a board of directors chaired by Fairleigh Dickinson and with startup funds already in hand.

Strategic Basis for the Federal Program

Meanwhile, back at the DHEW ranch, a number of philosophical and practical questions had been debated and resolved concerning the Federal component of the new health education initiative. The establishment of the Bureau at CDC and the Intradepartmental Committee (later, for procedural reasons, to be known as the Intradepartmental Panel on Health Education of the Public) was the result of a careful weighing of alternatives.

The considerations underlying these decisions merit some discussion as a backdrop to the actions taken. It was recognized from the outset that health education is, or should be, an essential element of nearly every Public Health Service program. It is an instrument for prevention and control of disease, an important service to be provided through health care delivery programs, and a key component of consumer protection activities. In addition, health education is a significant part of the programs of numerous Federal agencies outside the Service, both within and outside the Department of Health, Education, and Welfare.

The following partial listing is indicative of the breadth and diversity of health education responsibilities and activities in DHEW alone:

Public Health Service

Alcohol, Drug Abuse, and Mental Health Administration. Major education and communications programs related to alcoholism and drug abuse; educational activities related to other mental health problems of specific target populations—the young and their parents, the elderly, rural Americans, minority groups; educating these various populations as to the availability and use of treatment and rehabilitation services; and conduct and support of research related to health behavior.

Center for Disease Control. In addition to the activities of the Bureau of Health Education itself, educational activities in venereal disease control, immunization, environmental health problems, nutrition, working with and through State and local health agencies, and problems of occupational health and safety.

Food and Drug Administration. Programs of health education and information for the consumer and for industry; special emphasis currently being given to nutritional labeling of foods and over-the-counter drugs, working through consumer representatives in district offices across the country.

Health Resources Administration. Research and evaluation related to health behavior and improved education methodology; incorporation of appropriate health education emphasis in relation to the new National Health Planning and Resources Development Act; improvement of patient education in hospitals, long-term care facilities, and others.

Health Services Administration. Health education as an integral part of services provided by Maternal and Child Health, Migrant Health, Community Health Centers, Family Planning, and other service delivery programs; major health education activities in the Indian Health Service; inclusion of health education components in health maintenance organizations, emergency medical services, and so forth.

National Institutes of Health. Major health education initiatives of the Division of Cancer Control and Rehabilitation, National Cancer Institute; hypertension education program and other major educational activities of the National Heart and Lung Institute; and research in health behavior supported by these and other institutes.

Office of Education

Support and encouragement of improved health curriculums in public schools; stimulation of community interest in and support of comprehensive school health education in grades kindergarten through 12.

Social and Rehabilitation Service

Inclusion of health education and beneficiary information services in programs of the Medical Services Administration, and particularly in the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) for children and their parents.

Social Security Administration

Information to beneficiaries as to rights, entitlements, and availability of services.

Office of Human Development

Inclusion of health education in programs for the aging, the Head Start program for children, and others.

In designing the departmental strategy it was recognized that educational activities related to hypertension or drug abuse or venereal disease draw their substance from the control programs of which they are an integral part. By the same token, the educational activities of community health centers, migrant health programs, and others, are interwoven with other services provided. Education for health is an important objective of school programs, of services for the aged, and many other groups.

Therefore, the keystone of the DHEW strategy for health education was that each Agency and program should retain, and fulfill, its primary responsibility for health education related to its mission. It was decided that to divorce this responsibility from the programs through the creation of a separate superimposed health education bureaucracy would diminish the effectiveness of the total effort. It would also inevitably lead to widespread duplication of activity, since the Agencies and programs correctly feel compelled to continue some form of educational activity related to their respective goals. Thus the decision was made that it would be impractical and unwise to set up an agency which would attempt to "capture and run" the total health education effort.

This principle of primary responsibility in the programs was not interpreted to imply, however, that there was no need for coordinative and facilitating activities

across Agency lines. A preliminary survey of Public Health Service and other DHEW health education activities indicated clearly that the health education responsibilities of the various Agencies were being unevenly fulfilled. There was evidence of competition among programs for the attention of common target populations. Still more serious were the gaps in health education services resulting from inattention or low priority accorded to these services.

Therefore the objective was to establish a strategy for health education that would assure:

1. That each Agency and program define more precisely the health education component of its mission, assign adequate resources to, and be accountable for this component;
2. That a data base on health education activities of the Agencies and programs be established and maintained, and that information be continuously shared among the programs;
3. That existing mechanisms be more fully exploited, and new mechanisms be developed, for inter-Agency collaboration on health education problems and activities of mutual importance;
4. That one operating Agency be charged with the primary responsibility, serving as a source of technical assistance and consultation to other Agencies and as a stimulus for innovation in health education methodologies.

Accordingly, neither a major organizational realignment nor a great new infusion of resources was proposed to develop and carry out an effective health education strategy, but rather a concerted effort to make better use of the existing structure and the total resources currently devoted to health education.

The Intra-Departmental Panel

The Intra-Departmental Panel for Health Education of the Public held its first meeting in September 1974. The Panel is designed as an instrument for the development and promulgation of Department-wide health education policies and to encourage multi-agency health education activities. The Panel is chaired by the Assistant Secretary for Health and comprises the six Public Health Service agency heads, a Regional Health Administrator, the Assistant Secretary for Education, heads of Medicare and Medicaid programs, and representatives of several staff offices from the Office of the Secretary.

In practice, the Panel is providing a forum for discussion and a mechanism for recommending Department-wide health education policies and priorities at the highest level, and for encouraging Department-wide and interagency efforts directed toward the solution of health education problems common to several agencies. A liaison group, composed of key staff members designated by the agency heads, constitutes a working force to facilitate and implement interagency action, and to assure interchange of information among agencies.

Members of this group are the initial point of contact for the Bureau of Health Education in its work with the respective agencies. Task forces on target populations, research and evaluation, and reimbursement and insurance are currently developing recommendations for specific program activities.

Bureau of Health Education

The Bureau of Health Education was formally established at the Center for Disease Control in September 1974. Its placement in the CDC was based on the prevention mission of the Center, the existence in the CDC organization of a strong educational program in the National Clearinghouse on Smoking and Health, with which the Bureau was merged in the process of its formation, and the extensive network of CDC field personnel working at the State and community levels.

Before the formal establishment of the Bureau, CDC convened, in June 1974, a major national health education conference bringing together 150 recognized leaders in the field from all 50 States, from other Federal Agencies and regional offices, from local and voluntary agencies, and academic institutions. This initial national conference was asked to assist CDC in setting priorities for its new health education venture, and the conference report (6) has proved a most helpful guide.

Since that time the Bureau has continued its role as convener of meetings to address special issues related to health education. Groups of selected experts have been brought together to discuss such topics as patient education, health education as it should relate to health planning and resource development (P.L. 93-641), credentialing of health education practitioners, and behavioral research related to smoking and other forms of substance abuse.

The convening of meetings on special subjects is a part of the Bureau's function of providing consultation and professional services to those concerned with health education programs. Bureau staff members have traveled widely throughout the country, visiting projects in action and meeting, on request, with agencies and organizations at regional, State, and local levels. Direct consultation on programs has been provided to several State health departments and numerous public and private groups. Another aspect of this consultative role is the development of improved channels for widespread dissemination of professional information throughout the related professions.

A second major function of the Bureau is to provide direct support, through contracts, to a limited number of projects of special significance. As this article is written, approximately 30 such contracts are in being. Some of these continue, in modified form, contracts previously supported by the National Clearinghouse on Smoking and Health. Others represent new Bureau initiatives. The following four projects, briefly described, illustrate the kinds of activities in which the Bureau is engaged.

School health curriculum project. Support is continuing for the so-called Berkeley Project initiated several years ago by the National Clearinghouse. Health curriculums have been developed for the fourth, fifth, sixth, and seventh grades which relate to each other and cumulatively give to the children an exciting learning experience that enables them to understand and deal with health problems realistically. Keys to the success of the project have been the training of teacher-administrator teams and the involvement of parents and community health resources.

The Bureau will continue active support of this initiative, which is now in place in 175 school districts across the country. The model is being broadened to include other grades and will cover a wider range of health subject matter.

The Arkansas Cooperative Extension Service, with Bureau support, is extending and modifying its special health education program for rural communities originally supported through a grant from the Regional Medical Program. The intent is to develop a model for using the outreach network and the established credibility of the Extension Service as a channel for effective health education in rural areas. In Arkansas, close cooperation has been established at the county level between Extension and public health personnel. This base is being used as a means of identifying special health education needs and interests of rural people and developing ways to meet those needs.

The American Hospital Association will analyze and report on a wide range of information about patient health education services in hospitals. In concert with the Harvard University School of Public Health and concerned Federal programs, specific systems will be established to gather and analyze health education data pertinent to certain diseases, health situations, types of hospital settings, populations served, and so forth. This project is designed to serve as a basis for identification of successful programs that can be adapted and replicated, and as a launching pad for further efforts in patient education.

Kidney donor activities. Demonstration projects supported by the Bureau at the Mideast Organ Bank in Kansas City, Mo., and Emory University in Atlanta, Ga., are investigating the gap between the number of persons needing kidney transplants and the number of kidneys available for transplant and identifying program problems. The projects are attempting to assist the local programs in developing improved systems, which include health education methods, to increase the supply of kidneys available for transplant.

A third primary function of the Bureau of Health Education is to continue the work of the National Clearinghouse for Smoking and Health. In addition to the contract-supported projects previously mentioned,

several of which retain a significant component related to smoking, the services of the Clearinghouse include periodic surveys of the smoking habits of three population groups: teenagers, health professionals, and the adult U.S. public; publication of an annual report to the Congress on the "Health Consequences of Smoking"; continuing collection and review of the world literature related to these health consequences, and maintenance of a technical information service in this scientific field. The Clearinghouse responds directly to a large volume of inquiries from professionals and the public at large concerning many aspects of the smoking issue.

In addition, the Clearinghouse is working closely with the National Interagency Council on Smoking, a group made up of voluntary, professional, and governmental organizations, giving special emphasis at this time to the more effective involvement of young people in anti-smoking programs. In cooperation with several interested State health departments, a new initiative is being launched to test the effectiveness of State sponsorship and distribution of television spot announcements.

Finally, in discharging its responsibilities for providing a central point of reference for health education in the Federal Government, the Bureau conducts a number of liaison activities with other agencies. It provides staff services to the Intra-Departmental Panel and is in continuous contact with staff members of the member Agencies. It encourages and participates in interagency projects, some of which involve joint funding by two or more components of the Department. The Bureau provides consultation on request to other DHEW agencies in connection with grant and contract proposals related to health education and has been the lead agency in developing health education goals and standards for the new Health Planning and Resources Development Act.

One important Bureau project is the development of a solid data base on Federal health education activities and a system for keeping this base continually updated. A preliminary survey, conducted during the first few months of the Bureau's existence, revealed an extraordinary number and diversity of such activities and an estimate of at least \$80 million being spent in the Department for educational activities related to health. It also revealed the difficulty of identifying and tracking the range of health education programming. Rarely is health education separately identified as a "line item" of expenditure; in most instances it is built into the program in such a way that the educational component is hard to isolate and quantify. Moreover, the activities reported were a mixture of apples and aardvarks, ranging from public affairs or public relations activities with minimal educational content, at one extreme, to the delivery of health care in which education might or might not be carried out, more or less incidentally.

Nevertheless, the development of such a data base is viewed as essential to any systematic approach to health education in the Department, and the various agencies

are demonstrating a high degree of willingness to provide more useful and comparable data.

Eventually, of course, this data base and the mutual efforts it should generate must extend beyond the Department of Health, Education, and Welfare across the whole spectrum of Federal involvement in health education. Exploratory liaison activities are already underway with several other agencies, including the U.S. Departments of Agriculture, Defense, and Transportation, the Veterans Administration, and others. On the international scene, relationships are being established with the World Health Organization, and special support is being given to the forthcoming IX International Conference on Health Education, to be held in Ottawa, Canada, in August 1976.

Looking to the Future

The rising tide of interest in health education is visible throughout the Federal Government and the nation as a whole. In addition to the actions outlined in this paper, there are many other indicators of this trend.

In the Congress, a number of bills proposing significant new health education initiatives have been introduced in the 93d and 94th Congresses. As this article is written, one such bill, S. 1467, has been passed by the Senate, following hearings in the summer of 1975. In the House, several hearings were held in November 1975, and a revised bill (H.R. 12678) is awaiting action in the House. These bills propose changes in the structure of health education activities within the Federal Government and would authorize additional resources. Some, including the bill already passed by the Senate, would also give formal recognition and provide resources to a private-sector national center.

In other recent congressional action, P.L. 93-641, the Health Planning and Resources Development Act, lists health education among its 10 priorities, and guidelines are currently being drafted to assure that it receives due attention in the implementation of the act.

Within the Executive Branch, the Forward Plan for Health for Fiscal Years 1977-1981, published by the Public Health Service in June 1975, stresses the importance of health education as "... a principal vehicle for many prevention programs, particularly those directed at changing an individual's lifestyle..." The forward plan also highlights one of the major problems to which the field must address itself (7) :

A principal problem in assessing the state-of-the-art of health education has been the difficulty of evaluating programs. Further research is required to determine effectiveness measures. Cost benefit ratios, changes in utilization of certain services, the ability to convince people to take certain actions and changes in health status have all been used to determine the success of health education efforts.

A Task Force on Consumer Health Education, chaired by Anne R. Somers, presented an important working paper to the National Conference on Preventive Medicine in June 1975, a conference jointly

sponsored by the National Institutes of Health and the American College of Preventive Medicine. Along with a number of thoughtful and constructive recommendations, the task force presented a working definition of the field which is of great practical value (8) :

The term 'consumer health education' subsumes a set of activities which:

- (1) inform people about health, illness, disability, and ways in which they can improve and protect their own health, including more efficient use of the delivery system;
- (2) motivate people to want to change to more healthful practices;
- (3) help them to learn the necessary skills to adopt and maintain healthful practices and lifestyles;
- (4) foster teaching and communication skills in all those engaged in educating consumers about health;
- (5) advocate changes in the environment that facilitate healthful conditions and healthful behavior; and
- (6) add to knowledge via research and evaluation concerning the most effective ways of achieving the above objectives.

This comprehensive definition presents a formidable array of challenges. Clearly, these tasks can be accomplished only by concerted efforts, involving a very broad range of professions and disciplines, working across the lines that tend to separate agency from agency and public from private endeavors. The stage is set, but a great many actors will have to perform very well indeed.

Health education is not a panacea for all the ills of man, nor does it possess a magic formula for solving the problems and dilemmas of the national health care system. But given the increased emphasis implicit in the developments of the past few years, health education can take its rightful place as a major instrument for improving the health of the nation and its people.

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